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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2010-111

**ACCUSATION**

13 **GABRIEL MUNOZ**  
14 **12469 Los Moras**  
**Victorville, California 92392**

15 **Registered Nurse License No. 566484**

16 Respondent.

17  
18  
19 Complainant alleges:

20 **PARTIES**

21 1. Louise R. Bailey, MEd., RN ("Complainant") brings this Accusation solely in her  
22 official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"),  
23 Department of Consumer Affairs.

24 **Registered Nurse License**

25 2. On or about April 26, 2000, the Board issued Registered Nurse License Number  
26 566484 to Gabriel Munoz ("Respondent"). The registered nurse license was in full force and  
27 effect at all times relevant to the charges brought herein and will expire on August 31, 2009,  
28 unless renewed.



1 (b) Any device that bears the statement: "Caution: federal law restricts  
2 this device to sale by or on the order of a \_\_\_\_\_," "Rx only," or words of  
3 similar import, the blank to be filled in with the designation of the practitioner  
4 licensed to use or order use of the device.

5 (c) Any other drug or device that by federal or state law can be lawfully  
6 dispensed only on prescription or furnished pursuant to Section 4006.

7 8. Health and Safety Code section 11173 states:

8 (a) No person shall obtain or attempt to obtain controlled substances, or  
9 procure or attempt to procure the administration of or prescription for controlled  
10 substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the  
11 concealment of a material fact.

12 (b) No person shall make a false statement in any prescription, order,  
13 report, or record, required by this division.

14 (c) No person shall, for the purpose of obtaining controlled substances,  
15 falsely assume the title of, or represent himself to be, a manufacturer, wholesaler,  
16 pharmacist, physician, dentist, veterinarian, registered nurse, physician's assistant, or  
17 other authorized person.

18 (d) No person shall affix any false or forged label to a package or  
19 receptacle containing controlled substances.

20 9. Code section 118, subdivision (b), provides, in pertinent part, that the expiration of a  
21 license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the  
22 period within which the license may be renewed, restored, reissued or reinstated

### 23 COST RECOVERY

24 10. Code section 125.3 provides, in pertinent part, that the Board may request the  
25 administrative law judge to direct a licensee found to have committed a violation or violations of  
26 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
27 enforcement of the case.

### 28 11. DRUGS

"Ativan", a brand of lorazepam, is a Schedule IV controlled substance as designated by  
Health and Safety Code section 11057, subdivision (d)(13), and a dangerous drug under Code  
section 4022 in that under federal or state law it requires a prescription.

"Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated  
by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug under  
Code section 4022 in that under federal or state law it requires a prescription.



1 a registered nurse at St. Mary's Medical Center, Apple Valley, California and was subsequently  
2 terminated by the medical center.

3 **THIRD CAUSE FOR DISCIPLINE**

4 **(Inconsistent/Unintelligible Entries in Patient Records)**

5 14. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on  
6 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that  
7 on or about March 20 through March 21, 2006, while on duty as a registered nurse at St. Mary's  
8 Medical Center, Apple Valley, California, Respondent falsified or made grossly incorrect,  
9 inconsistent or unintelligible entries in the following hospital and/or patient records:

10 **Patient A<sup>1</sup>**

11 a. On March 20, 2006, at 1530 hours, Respondent signed out 4 mg of Morphine from  
12 the Pyxis System<sup>2</sup> for this patient; however, Respondent failed to chart the administration or  
13 wastage of any portion of the Morphine in any patient or hospital record or otherwise account for  
14 the disposition of the drug.

15 **Patient C**

16 b. On March 20, 2006, at 0711 hours, Respondent signed out 2 mg of Dilaudid from the  
17 Pyxis System for this patient. Respondent charted the administration of 1 mg of Dilaudid in the  
18 patient's medication administration record; however, Respondent failed to chart the  
19 administration or wastage of the remaining 1 mg of Dilaudid in any patient or hospital record or  
20 otherwise account for the disposition of the remaining 1 mg of Dilaudid.

21 c. On March 20, 2006, at 0858 hours, Respondent signed out 2 mg of Dilaudid from the  
22 Pyxis System for this patient. Respondent charted the administration of 1 mg of Dilaudid in the  
23 patient's medication administration record; however, Respondent failed to chart the  
24 administration or wastage of the remaining 1 mg of Dilaudid in any patient or hospital record or  
25 otherwise account for the disposition of the remaining 1 mg of Dilaudid.

26 <sup>1</sup> Initials are used to protect the privacy of the patients. The patients' full names will be  
27 provided following a request for discovery.

28 <sup>2</sup> Pyxis is a system for the automated dispensing and management of medications at the  
point of use in hospital settings.

1           **Patient D**

2           d.     On March 20, 2006, at 1955 hours, Respondent signed out 10 mg of Morphine from  
3 the Pyxis System for this patient. Respondent charted the administration of 2 mg of Morphine,  
4 each time, at 1845 hours, 1850 hours, 1855 hours and 1955 hours in the patient's medication  
5 administration record; however, Respondent failed to chart the administration or wastage of the  
6 remaining 2 mg of Morphine in any patient or hospital record or otherwise account for the  
7 disposition of the remaining 2 mg of Morphine.

8           **Patient E**

9           e.     On March 21, 2006, at 0911 hours, Respondent signed out 2 mg of Dilaudid from the  
10 Pyxis System for this patient; however, Respondent failed to chart the administration or wastage  
11 of any portion of the Dilaudid in any patient or hospital record or otherwise account for the  
12 disposition of any portion of the drug.

13           **Patient F**

14           f.     On March 20, 2006, at 0741 hours, Respondent signed out 10 mg of Morphine from  
15 the Pyxis System for this patient. Respondent charted the administration of 4 mg of Morphine in  
16 the patient's administration record; however, Respondent failed to chart the administration or  
17 wastage of the remaining 6 mg of Morphine in any patient or hospital record or otherwise account  
18 for the disposition of the remaining 6 mg. of Morphine.

19           g.     On March 20, 2006, at 1117 hours, Respondent signed out 4 mg of Morphine from  
20 the Pyxis System for this patient; however, Respondent failed to chart the administration or  
21 wastage of any portion of the Morphine in any patient or hospital record or otherwise account for  
22 the disposition of the drug.

23           **Patient G**

24           h.     On March 21, 2006, at 1221 hours, Respondent signed out 4 mg of Dilaudid from the  
25 Pyxis System for this patient. Respondent charted the administration of 1 mg of Dilaudid in the  
26 patient's medication administration record; however, Respondent failed to chart the  
27 administration or wastage of any portion of the remaining 3 mg of Dilaudid in any patient or  
28 hospital record or otherwise account for the disposition of the drug.

1           **Patient H**

2           i.       On March 20, 2006, at 1640 hours, Respondent signed out 10 mg of Morphine from  
3 the Pyxis System for this patient. Respondent charted the administration of 4 mg of Morphine in  
4 the patient's medication administration record and nurse's notes; however, Respondent failed to  
5 chart the administration or wastage of any portion of the remaining 6 mg of Morphine in any  
6 patient or hospital record or otherwise account for the disposition of the drug

7           j.       On March 20, 2006, at 1840 hours, Respondent signed out 2 mg of Ativan from the  
8 Pyxis System for this patient. Respondent charted the administration of 1 mg of Ativan in the  
9 patient's medication administration record and nurse's notes; however, Respondent failed to chart  
10 the administration or wastage of any portion of the remaining 1 mg of Ativan in any patient or  
11 hospital record or otherwise account for the disposition of the drug.

12           **Patient I**

13           k.       On March 21, 2006, at 0908 hours, Respondent signed out 1 Vicodin tablet from the  
14 Pyxis System for this patient; however, Respondent failed to chart the administration or wastage  
15 of the Vicodin tablet in any patient or hospital record or otherwise account for the disposition of  
16 the drug.

17           **Patient J**

18           l.       On March 20, 2006, at 0748 hours, Respondent signed out 2 mg of Dilaudid from the  
19 Pyxis System for this patient; however, Respondent failed to chart the administration or wastage  
20 of any portion of the 2 mg of Dilaudid in any patient or hospital record or otherwise account for  
21 the disposition of the drug.

22           **COMMUNITY HOSPITAL OF SAN BERNARDINO**

23                           **FOURTH CAUSE FOR DISCIPLINE**

24                           **(Obtained, Possessed, Self-Administered and Furnished a Controlled Substance)**

25           15.       Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on  
26 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that  
27 on or about April 27, 2005, through May 5, 2005, while on duty as a registered nurse at  
28

1 Community Hospital of San Bernardino, San Bernardino, California, Respondent committed the  
2 following acts:

3 a. Respondent obtained unknown quantities of the controlled substances Dilaudid and  
4 Morphine by fraud, deceit, misrepresentation, or subterfuge by taking the drugs from hospital  
5 supplies in violation of Health and Safety Code section 11173, subdivision (a).

6 b. Respondent possessed unknown quantities of the controlled substances Dilaudid and  
7 Morphine without a lawful prescription, in violation of Code section 4022.

8 **FIFTH CAUSE FOR DISCIPLINE**

9 16. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on  
10 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that  
11 on or about April 27, 2005, through May 5, 2005, while on duty as a registered nurse at  
12 Community Hospital of San Bernardino, San Bernardino, California, Respondent falsified or  
13 made grossly incorrect, inconsistent or unintelligible entries in the following hospital and/or  
14 patient records:

15 **Patient No. 050**

16 a. On May 2, 2005, at 0124 hours, Respondent signed out 2 mg of Dilaudid from the  
17 Pyxis System for this patient. Respondent charted the administration of 1 mg of Dilaudid in the  
18 patient's medication administration record; however, Respondent failed to chart the  
19 administration or wastage of any portion of the remaining 1 mg. of Dilaudid in any patient or  
20 hospital record or otherwise account for the disposition of the drug.

21 **Patient No. 775**

22 b. On April, 30, 2005, at 2027 hours, Respondent signed out 2 mg of Dilaudid from the  
23 Pyxis System for this patient; however, Respondent failed to chart the administration or wastage  
24 of any portion of the Dilaudid in any patient or hospital record or otherwise account for the  
25 disposition of the drug.

26 **Patient No. 896**

27 c. On May 2, 2005, at 0131 hours, Respondent signed out 2 mg of Dilaudid from the  
28 Pyxis System for this patient. Respondent charted the administration of 1 mg of Dilaudid in the

1 patient's nurse's notes; however, Respondent failed to chart the administration or wastage of any  
2 portion of the remaining 1 mg. of Dilaudid in any patient or hospital record or otherwise account  
3 for the disposition of the drug.

4 **Patient No. 734**

5 d. On April 30, 2005, at 2235 hours, Respondent signed out 2 mg of Dilaudid from the  
6 Pyxis System for this patient; however, Respondent failed to chart the administration or wastage  
7 of any portion of the 2 mg. of Dilaudid in any patient or hospital record or otherwise account for  
8 the disposition of the drug.

9 **Patient No. 979**

10 e. On May 2, 2005, at 0259 hours, Respondent signed out 2 mg of Dilaudid from the  
11 Pyxis System for this patient. Respondent charted the administration of 0.5 mg of Dilaudid in the  
12 patient's medication administration record; however, Respondent failed to chart the  
13 administration or wastage of any portion of the remaining 1.5 mg. of Dilaudid in any patient or  
14 hospital record or otherwise account for the disposition of the drug.

15 **Patient No. 114**

16 f. On April 30, 2005, at 0453 hours, Respondent signed out 10 mg of Morphine from  
17 the Pyxis System for this patient; however, Respondent failed to chart the administration or  
18 wastage of any portion of the 10 mg of Morphine in any patient or hospital record or otherwise  
19 account for the disposition of the drug.

20 **Patient No. 113**

21 g. On May 1, 2005, at 0703 hours, Respondent signed out 2 mg of Dilaudid from the  
22 Pyxis System for this patient; however, Respondent failed to chart the administration or wastage  
23 of any portion of the 2 mg of Dilaudid in any patient or hospital record or otherwise account for  
24 the disposition of the drug.

25 **Patient No. 965**

26 h. On May 1, 2005, at 0350 hours, Respondent signed out 10 mg of Morphine from the  
27 Pyxis System for this patient; however, Respondent failed to chart the administration or wastage  
28

1 of any portion of the Morphine in any patient or hospital record or otherwise account for the  
2 disposition of the drug.

3 **Patient No. 631**

4 i. On May 1, 2005, at 2159 hours and 2335 hours, Respondent signed out 2 mg of  
5 Dilaudid each time from the Pyxis System for this patient. Respondent charted the wastage of 1  
6 mg of Dilaudid at each time interval at 2335 hours and 2336 hours. Respondent charted the  
7 administration of 1 mg of Dilaudid in the patient's medication administration record; however,  
8 Respondent failed to chart the administration or wastage of any portion of the remaining 1 mg. of  
9 Dilaudid in any patient or hospital record or otherwise account for the disposition of the drug.

10 **EAST VALLEY HOSPITAL MEDICAL CENTER**

11 **SIXTH CAUSE FOR DISCIPLINE**

12 **(Unprofessional Conduct - Used Controlled Substances)**

13 17. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on  
14 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (b), in that  
15 on or about April 24, 2005, Respondent used controlled substances to an extent that such use  
16 impaired his ability to practice safely. Respondent tested positive for opiates, barbiturates, and  
17 benzodiazepines while on duty as a registered nurse at East Valley Hospital Medical Center,  
18 Glendora, California and was subsequently terminated by the medical center.

19 **PRAAYER**

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
21 and that following the hearing, the Board of Registered Nursing issue a decision:

22 1. Revoking or suspending Registered Nurse License Number 566484, issued to  
23 Gabriel Munoz;

24 2. Ordering Gabriel Munoz to pay the Board of Registered Nursing the reasonable costs  
25 of the investigation and enforcement of this case, pursuant to Business and Professions Code  
26 section 125.3; and,

27 ///

28 ///

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/28/09

*Louise R. Bailey*

LOUISE R. BAILEY, MEd., RN  
Interim Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
*Complainant*

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